

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

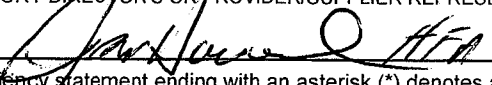
PRINTED: 02/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2011
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NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 WEST VINE STREET PRINCETON, IN 47670
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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/15/11</p> <p>Facility Number: 000175 Provider Number: 155275 AIM Number: 100274440</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Princeton was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 95 and had a census of 62 at the time of this survey.</p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 02/17/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as</p>	K 000	<p>RECEIVED</p> <p>MAR - 7 2011</p> <p>LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO/Administrator	(X6) DATE 2-28-11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

APPROVED

3/10/11 GA

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K 000	Continued From page 1	K 000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>K021 It is the intent of this facility to ensure the smoke barrier door automatically closes upon activation.</p> <p>I. Actions taken for the residents identified:</p> <p>#1. There were no specific residents Identified on the 2567 to be Effected.</p> <p>II. How other residents were identified:</p> <p>#2. No other residents were identified As being effected.</p>	
K 021 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure once the fire alarm system is activated 7 of 7 sets of smoke barrier doors and 1 of 1 single smoke barrier door would remain self closing until the fire alarm system is returned to normal operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 02/15/11 at 12:15 p.m. during a tour with the Maintenance Supervisor, all seven sets of smoke barrier doors and one single smoke barrier door released initially with the fire</p>	K 021		

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: S3B421 Facility ID: 000175 If continuation sheet Page 3 of 5

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K 144	<p>Continued From page 3</p> <p>where the probability of interruption of off site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. CMS requires evidence of reliability of the natural fuel source must contain all of the following:</p> <ul style="list-style-type: none"> a. A statement of reasonable reliability of the natural gas delivery; b. A brief description the supports the statement regarding the reliability; c. A statement there is a low probability of interruption of the natural gas; d. A brief description that supports the statement regarding the low probability of interruption; e. The signature of technical personnel from the natural gas vendor. <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 02/15/11 at 11:00 a.m. during a tour of the facility with the Maintenance Supervisor, the emergency generator was powered with natural gas only. This was acknowledged by the Maintenance Supervisor at the time of observation. During an interview at 12:05 p.m., the Administrator indicated the facility did not have a letter from their natural gas provider as evidence of reliability of their natural gas supply.</p>	K 144	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p style="text-align: center;">K144</p> <p>It is the intent of this facility To ensure that the facility has documentation to show the reliability of Natural gas from our supplier</p> <p>I. Actions taken for the residents identified:</p> <p>#1. There were no specific residents Identified on the 2567 to be Effected.</p> <p>II. How other residents were identified:</p> <p>#2. No other residents were identified As being effected.</p>	

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K 144 Continued From page 4

3.1-19(b)

K 144

III. Systems in place:

#3. The facility has received a
Letter from our natural gas
Provider, showing evidence
Of reliability of our natural
Gas supply.

IV. How the actions will be monitored

#4. CEO/Designee will review
The gas letters reliability
To remain in compliance
And be reviewed at the
Quarterly QA meeting

V. Date of completion:

This plan of correction constitutes our
credible allegation of compliance with
all regulatory requirements. Our date of
compliance is 2-21-2011